SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Dental	SERFF Tr Num: AEGX-126202433	State: ArkansasLH
TOI: H10I Individual Health - Dental	SERFF Status: Closed	State Tr Num: 42748
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: DN AR0041315C02	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 06/24/2009
	Date Submitted: 06/23/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Dental	Status of Filing in Domicile: Not Filed
Project Number: DN AR0041315C02	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: Resubmission	Previous Filing Number: 38713
Group Market Size:	Overall Rate Impact:
Group Market Type:	Filing Status Changed: 06/24/2009
Explanation for Other Group Market Type:	
State Status Changed: 06/24/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Dear Commissioner Bradford:

The above captioned Individual Supplemental Dental Insurance Policy and related materials are being resubmitted for your department review and approval. The following is in response to your objection letter dated April 23, 2008.

Objection 1

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
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Pursuant to ACA 23-79-129, we have revised the Newborn and Adopted Children provision to reflect coverage for newborn infants to be 90 days.

Moreover, pursuant to ACA 23-79-137, we have revised the Newborn and Adopted Children provision to reflect coverage for adopted children to begin on the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. The coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the adopted child.

Objection 2

Pursuant to ACA 23-85-131(b) and Bulletin 14-81 with respect to handicapped dependents, we have revised the EXCEPTION under Item #2 on page 5 to state: EXCEPTION: At age 26, a Covered Dependent child's coverage may continue under this Policy as long as it remains in force if the child is incapable of self support due to a mental or physical handicap and remains in such condition. We must receive your written request prior to the child attaining age 26. The premium charged is that of a Covered Dependent child.

Please note form D493 AR is replacing form D493.

We believe these revisions will assist in your further review and with optimism, subsequent approval. Your time and consideration regarding this filing is greatly appreciated.

Sincerely,

Kimberly Taylor, AIRC, ACS

Company and Contact

Filing Contact Information

Kimberly Taylor, Filing Specialist kimtaylor@aegonusa.com

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
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520 Park Avenue
Baltimore, MD 21201

(410) 209-5261 [Phone]
(410) 209-5910[FAX]

Filing Company Information

Stonebridge Life Insurance Company
29 South Main Street
Rutland, VT 05701-5014
(410) 685-5500 ext. [Phone]

CoCode: 65021
Group Code: 468
Group Name:
FEIN Number: 03-0164230

State of Domicile: Vermont
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$100.00	06/23/2009	28761256

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/24/2009	06/24/2009

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Disposition

Disposition Date: 06/24/2009
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Stonebridge Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
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Product Name:	*Dental*		
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Explanation of Variables - D493 AR	Approved-Closed	Yes
Supporting Document	AR Actuarial Exhibit C	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT	Approved-Closed	Yes
Form	Individual Supplemental Dental Insurance Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	IGH003 - Application	Approved-Closed	Yes
Rate	Rates - D493 AR	Approved-Closed	Yes
Rate	Actuarial Memo - D493 AR	Approved-Closed	No

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: D493 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	D493 AR	Policy/Contract/Fraternal Certificate	Individual Supplemental Dental Insurance Policy	Revised	Replaced Form #: Previous Filing #:	42	D493 AR.PDF
Approved-Closed	D493 O.C.	Other	Outline of Coverage	Other	Other Explanation: resubmission	0	D493 O_C_.PDF
Approved-Closed	IGH003	Application/Enrollment Form	IGH003 - Application	Other	Other Explanation: resubmission	0	IGH003.PDF

Stonebridge Life Insurance Company

[Home Office: Rutland, Vermont]
[Administrative Office: 2700 W. Plano Parkway, Plano, TX 75075]
[1-800-732-1821]

SUPPLEMENTAL DENTAL INSURANCE POLICY

PRINCIPAL INSURED: **[John Doe]** POLICY NUMBER: **[12345]**

This is a dental insurance Policy. In this Policy, Stonebridge Life Insurance Company is referred to as "we," "our," or "us." The Principal Insured is "you," "your," or "yours." This Policy is a legal contract. You rely on us to honor its terms. We depend on your payment of premiums when due.

RENEWABLE AT THE OPTION OF THE COMPANY: We promise to renew this Policy as long as you pay your premium when due. We will not renew this Policy if: (1) we do not renew all other policies that are issued to everyone in your Class or in the state where it was issued; or (2) because you performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

YOUR RIGHT TO EXAMINE THE POLICY FOR 30 DAYS: You may return this Policy and cancel your coverage for any reason within 30 days of the date you receive the Policy. Any premium payment is returned. The Policy is treated as if it never existed. No benefits are paid.

TABLE OF CONTENTS

READ YOUR POLICY CAREFULLY

SUPPLEMENTAL DENTAL INSURANCE POLICY
PREMIUMS ARE SUBJECT TO CHANGE

POLICY SCHEDULE

PRINCIPAL INSURED: **[John Doe]**

INSURED DEPENDENTS: **[Jane Doe]**
[All Covered Dependent Children]

POLICY EFFECTIVE DATE: **[9/30/2006]**

POLICY NUMBER: **[12345]**

INITIAL PREMIUM: **[$XX.XX]** INITIAL TERM: **[One Month]**

RENEWAL PREMIUM:			
[$XX.XX]	**[$XXX.XX]**	**[$XXX.XX]**	**[$XXX.XX]**
Monthly	Quarterly	Semi-Annually	Annually

POLICY BENEFITS:

Basic Eligible Expenses Covered up to [50%] *
Major Eligible Expenses Covered up to [50%]*
Waiting Period for Major Dental Services: [180 Days]
Calendar Year Deductible (per Insured): [$50.00]
Calendar Year Deductible (per Family): [$150.00]
Calendar Year Maximum Benefit (per Insured): [$1,250.00]

***Policy Benefits are subject to Coordination of Benefits section.**

PART I: DEFINITIONS

A. "AGE" means on the Effective Date, an Insured's current age based on his last birthday. An Insured's age on the Effective Date will increase by one year on each Policy Anniversary. An Insured's age increase for purposes of this Policy will always occur on the Policy Anniversary, even if his actual birthday occurs (in most cases) during the Policy Year prior to the Policy Anniversary.

B. "CALENDAR YEAR" means a twelve month period beginning on January 1 and ending on December 31.

C. "CALENDAR YEAR DEDUCTIBLE" means the amount of Eligible Expenses that an Insured must incur each Calendar Year before benefits are payable. Any amount that you paid during the last three months of the previous year for an Insured's Eligible Expenses and which are applied to that year's Calendar Year Deductible are applied to the Insured's current year's Calendar Year Deductible

D. "CALENDAR YEAR MAXIMUM BENEFIT" means the maximum amount of benefits we pay each Calendar Year for an Insured's covered Dental Services.

E. "POLICY ANNIVERSARY" means any anniversary of the date this Policy takes effect.

F. "POLICY EFFECTIVE DATE" means the date your coverage starts. It is shown on the Policy Schedule.

G. "POLICY YEAR" means the 12 month period ending on any Policy Anniversary.

H. "CLASS" means a group of people with the same rate classification and who reside in the same state when their Policies are issued.

I. "CO-PAYMENT" means the portion of an Eligible Expense, other than a Deductible, that you are required to pay. This does not include any amount charged by a non-Network Dentist that exceeds the Eligible Expense.

J. "COVERED DEPENDENT" means any Dependent who is insured under your Policy.

K. "DENTAL DISEASE" means any malady of the teeth, the teeth-supporting bone (alveolar process), residual bony ridge without teeth, and other supporting structures including, but not limited to, infection, developmental and/or genetic anomaly and neoplasm. "Dental Disease" usually refers to caries, periodontal disease, injury, degenerative or neoplastic condition of these tissues.

L. "DENTAL PROCEDURE" means the specific procedure, treatment, device, or pharmacological regimen used by a Dentist to correct or treat a dental condition or disease.

M. "DENTAL SERVICE" means the types of dental care and treatment that are covered by this Policy and which are provided by a Dentist or under the supervision of a Dentist.

N. "DENTIST" means a person who is licensed to practice dentistry and who is operating within the scope of his license. It does not mean a member of an Insured's Immediate Family.

O. "DEPENDENT" means: (1) your lawful spouse and (2) your unmarried child(ren) who are under age 26. Child(ren) means your natural children, stepchildren, legally adopted children, or foster children.

P. "ELIGIBLE EXPENSE" means the amount that we use to base benefit payment for a covered Dental Service and Procedure.

Q. "EMERGENCY" means a dental condition or symptom resulting from Dental Disease and which arises suddenly and requires immediate care or treatment by a Dentist. Such treatment must be sought or received within twenty-four hours after the onset of the condition or symptom.

R. "IMMEDIATE FAMILY MEMBER" means your spouse, parent, child, brother or sister, or any person living with you.

S. "INSURED" means you and your Covered Dependents who are insured under this Policy.

T. "LAPSE" means the Policy coverage stops because the premium is not paid by the end of the Grace Period.

U. "NECESSARY" means Dental Services and supplies which are determined by us to be appropriate and:

a. necessary to meet the basic dental needs of the Insured;
b. rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Dental Service;
c. consistent in type, frequency, and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us;
d. consistent with the diagnosis of the condition;
e. required for reasons other than the convenience of an Insured or his Dentist; and
f. demonstrated through prevailing peer-reviewed medical and/or dental literature to be either: a) safe and effective for treating or diagnosing the Dental Disease or condition for which their use is proposed; or b) safe with promising efficacy for treating a life threatening Dental Disease or condition, in a clinically controlled research setting, or using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

V. "NETWORK" means a group of Dentists who are subject to the participation agreement in effect with us or through another entity to provide Dental Services to persons who are covered under the Policy.

W. "PRINCIPAL INSURED" means only the person who applied for coverage and who is named as the "Principal Insured" on the Policy Schedule.

PART II: WHEN THE COVERAGE STARTS AND STOPS

A. WHEN COVERAGE STARTS

Before this coverage takes effect: (1) you must apply; and (2) we must receive your first premium **[**before**]** **[**within 21 days of**]** the Policy Effective Date. Your coverage then starts at 12:01 AM, Standard Time, at your home on the Policy Effective Date. If these two things do not happen, your Policy is void from the start. No benefits are paid for any loss.

NOTE: If you cancel or Lapse this Policy, we can reject any new enrollment form or application that you submit for any dental insurance plan that is offered by us. We can reject any such enrollment form or application for a period of one year following the date of cancellation or Lapse.

ADDING A DEPENDENT: In order to cover any eligible Dependent not insured on the Effective Date, you must submit an Application. Before the Dependent's coverage takes effect, two things must happen: (1) we must receive your Application for the Dependent; and (2) you pay any required additional premium. The Effective Date of coverage for the additional Dependent shall be the date shown on our endorsement indicating such addition.

NEWBORN AND ADOPTED CHILDREN: Any child born to an Insured is covered for 90 days from the moment of birth. Any adopted child of an Insured is covered from the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. However, an adopted child is covered from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after their birth.

Coverage then stops unless you:

a. send us a written request to continue coverage; and
b. pay the extra premium, if any.

No extra premium is due when at least one child is already insured under your Policy.

B. WHEN COVERAGE STOPS

Coverage under this Policy stops on the earliest of:

1. the date all policies that were issued to everyone in your Class are not renewed by us (You will be notified 60 days in advance of the date that your Policy is not being renewed).
2. the date the 31 day Grace Period ends if you fail to pay the premium when due (NOTE: If payment is made by credit card or automated account deductions, you must notify us in writing to cancel this insurance. See the "Payment Cancellation" provision.);
3. the date we receive your written request to cancel. (**Note Concerning Cancellation:** The provision entitled "Your Right To Examine The Policy For 30 Days" explains the rules for cancellation when your coverage is first issued. After that period the "Cancellation" provision applies.); or
4. the date we specify that your Policy stops because we determine that you performed an act or practice that constitutes fraud or material misrepresentation regarding: (1) an Insured's eligibility for coverage due to state of residence or status as a Dependent; or (2) any claim submitted for Dental Services.

A Covered Dependent's coverage also stops if the following happens:

1. **Covered Dependent Spouse:** A Covered Dependent spouse's coverage also stops on the premium due date after a change in marital status. If this happens, the Covered Dependent spouse may apply for a Policy with similar benefits. We must receive a written request within 60 days of the change in marital status. The spouse then pays the premium for a single adult at his age.
2. **Covered Dependent Child:** A Covered Dependent child's coverage also stops when the child: (1) marries or (2) turns age 26

   If one of these happens, the Covered Dependent child may apply for his own Policy with similar benefits. We must receive a written request within 60 days of when coverage stops. The child then pays the premium for a single adult.

   EXCEPTION: At age 26, a Covered Dependent child's coverage may continue under this Policy as long as it remains in force if the child is incapable of self support due to a mental or physical handicap and remains in such condition. We must receive your written request prior to the child attaining age 26. The premium charged is that of a Covered Dependent child.

D. PRINCIPAL INSURED'S DEATH

If you die while your Policy is in force, your Covered Dependent Spouse, if any, becomes the Principal Insured. We must receive notice of your death. His premium rate will be that of a Principal Insured based on his Age and Class at the time this Policy is issued.

E. EXTENDED COVERAGE

A conditional thirty day extension of coverage takes effect if an Insured's coverage under the Policy stops for any reason except if you cancel the Policy. It stops on the end of the thirty day period or, if earlier, the day the Insured becomes covered under a new policy or contract that provides coverage for similar Dental Services. The extension applies to the following:

1. Dental Services or Procedures that were recommended and begun prior to the date coverage stops;
2. an appliance or a modification to an appliance for which an impression was taken prior to the date coverage stops; or
3. a crown, bridge, or gold restoration for which the tooth was prepared prior to the date coverage stops.

PART III: WHAT BENEFITS WE PAY

This Policy pays benefits for covered Basic and Major Dental Services. The Dental Services are listed in the section titled "Covered Dental Services." To be eligible for payment, Dental Services must be received while the Insured's coverage under this Policy is in force. All Dental Services must be Necessary and provided by or under the direction of a Dentist. Dental Services may be provided by a Network Dentist or a non-Network Dentist.

The benefit amount that we pay for a covered Dental Service is based on the Dental Service's Eligible Expense. Different criteria are used to determine the Eligible Expenses for Dental Services provided by Network Dentists and those provided by non-Network Dentists.

Dental Services Provided by Network Dentists: An Eligible Expense for a Dental Service is the amount that Network Dentists are contractually obligated to charge everyone who is insured under the Policy. Network Dentists are not permitted to charge an Insured more than the Eligible Expense.

Dental Services Provided by non-Network Dentists: An Eligible Expense for a Dental Service is the smaller of (1) the amount a Dentist charges an Insured; (2) the Medium Charge; or (3) 85% of the usual and customary charge for the geographical region where the Dental Service is received. A Medium Charge is the amount that half the Dentists in a geographical region charge more and half charge less for the same Dental Service. No benefits are payable for any portion of a Dentist's charge that exceeds an Eligible Expense. (Example: If we determine that the Medium Charge in your geographic region is $100.00 and your Dentist charges $125.00, we consider $100.00 to be the Eligible Expense. If, however, 85% of the usual and customary charge equals $95.00, then we consider $95.00 to be the Eligible Expense. If your Dentist charges $75.00, we consider $75.00 to be the Eligible Expense.)

We pay the same percentage of an Eligible Expense when a covered Dental Service is provided by a Network or non-Network Dentist. The percentages that we pay for Basic and Major Dental Services are shown on the Policy Schedule. You are responsible for paying the difference between the benefit amount that we pay and the Eligible Expense. This difference is the Co-Payment. You are also responsible for paying any amounts charged by a non-Network Dentist that exceed an Eligible Expense.

Calendar Year Deductible: No benefits are paid in a Calendar Year for Basic and Major Dental Services until the Insured's Calendar Year Deductible is satisfied. The Calendar Year Deductible is shown on the Policy Schedule.

Calendar Year Maximum Benefit: A Calendar Year Maximum Benefit applies to each Insured. It is shown on the Policy Schedule. It is the total amount of benefits that we pay in a Calendar Year for each Insured. You are responsible for any charges for Dental Services that an Insured receives after he has met his Calendar Year Maximum Benefit.

Waiting Period For Major Dental Services: Benefits are not paid for Major Dental Services that are received during a Waiting Period. A Waiting Period begins on an Insured's effective date of coverage. The Waiting Period is shown on the Policy Schedule.

Alternative Procedures: If two or more Dental Procedures are adequate and appropriate treatment to correct a condition, the benefit payment is based on the Eligible Expense for the least expensive Dental Procedure. We can request an Insured's dental x-rays and records to help us determine which Dental Procedure we will consider for payment. If we do not receive the x-rays or records, we will decide which Dental Procedure is adequate and appropriate treatment to correct the condition. We will make adjustments that we deem proper if we later receive the x-rays and records and determine that a different Dental Procedure is more appropriate.

Pre-Treatment Estimate: You should request from us a pre-treatment estimate if the charges for a recommended Dental Service(s) exceeds $300.00. We must receive the Dentist's treatment plan that includes a description of the condition, the Dental Service(s) and the Dental Procedure(s) to be performed, and any supporting x-rays. We will inform you and the Dentist what Dental Service(s) and Procedure(s) that we cover and their Eligible Expense. If you do not request a pre-treatment estimate, we will determine the Dental Service(s) and Procedure(s), if any, that we cover when we review the claim for payment.

PART IV: COORDINATION OF BENEFITS

If any person under the Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and

2. the benefits that would be payable under all other plans without provisions for coordination in those plans would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other plans will not exceed the total of those Eligible Expenses. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the benefits of a plan covering such person as a dependent.
2. Except as stated in (3) below, when this Plan and another plan cover the same child as a dependent of different persons, called "parents":
   a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b. if both parents have the same birthday, the benefits of the plan covering the parent longer are determined before benefits of the plan covering the other parent for the shorter period of time. However, if the other plan does not have the rule described in a. above, but instead uses a different method, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:
   a. first, the plan of the parent with custody of the child;
   b. then, the plan of the spouse of the parent with custody of the child; and
   c. finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of such parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any Claim Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
4. If none of the above rules determines the order of benefits, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a plan covering the person the shorter period of time.

If we are responsible for secondary coverage for Eligible Expenses, we will not deny coverage or payment of the amount we owe as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This will not require us to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Plan or any similar provisions of other plans, we may, without consent or notice to any person, release to or obtain from any other insurance

company, organizations or person, any information concerning any individual which we consider necessary. Any person claiming benefit under this Plan will furnish us with any information necessary.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other plans, we will have the right, at our sole discretion, to pay any organizations making these payments any amount we determine to be due. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, We will be fully discharged from liability under this Plan.

Whenever payments have been made by us, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, within 12 months of payment, we will have the right to recover the excess from one or more of the following: (1) other insurance companies; (2) other organizations; or (3) persons to or for whom payments were made.

BENEFITS SUBJECT TO COORDINATION: All benefits provided under this Policy are subject to coordination.

DEFINITIONS: The following definitions apply only to this Coordination of Benefits section:

1. The term "Plan" means coverage providing hospital, medical or dental benefits or services by:
   a. group or blanket insurance coverage except school accident coverage;
   b. group Blue Cross and Blue Shield, group practice or other pre-payment coverage on a group basis; or
   c. labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans.

   "Plan" will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.
2. The term "Eligible Expense" means any necessary, reasonable and customary item of expense all or part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.
3. The term "Claim Period" means a calendar year or portion of a calendar year for a claim on a person covered under this Plan.

COVERED DENTAL SERVICES

Basic Dental Services

1. Adjunctive Services

Analgesia

Desensitizing Medicament

General Anesthesia: Covered only if required for Insureds who are under the Age of 6 years or Insureds who have behavioral problems or physical disabilities.

Intravenous Sedation and Analgesia

Occlusal Adjustment

Occlusal Guards: Limited to one guard during a five year period

Palliative Treatment: Covered only if no other Dental Service other than examination and radiographs were done during the visit.

2. Minor Restorative Services

Amalgam Restorations: Multiple restorations on one surface will be treated as a single filling.

Composite Resin Restorations

Pin Retention: Limited to two pins per tooth.

Space Maintainers: Limited to Insureds who are under the Age of 16 years and only one time during their lifetime. Benefit includes all adjustments within the six month period after installation.

Provisional Splinting

Major Dental Services

1. Crowns: Limited to one crown per tooth during a 5 year period and only when a filling cannot restore the tooth.

2. Endodontics

- **Apexification**
- **Apicoectomy and Retrograde Filling**
- **Hemisection**
- **Root Canal Therapy**
- **Root Resection**
- **Therapeutic Pulpotomy**

3. Fixed Bridges

4. Full Dentures: No additional allowances for over-dentures or customized dentures.

5. Gold Inlays and Onlays: Limited to one time during a five year period and only where amalgam (silver) fillings cannot restore the tooth.

6. Oral Surgery

- **Alveoloplasty**
- **Biopsy**
- **Frenectomy**
- **Incision and Drainage**
- **Removal of a Benign Cyst**
- **Removal of Exostosis**
- **Root Recovery**
- **Root Removal**
- **Simple Extraction**
- **Surgical Extraction of Erupted Teeth and Roots**
- **Surgical Extraction of Impacted Teeth**

7. Partial Dentures: No additional allowances for precision or semi-precision attachments.

8. Periodontics

- **Crown Lengthening***
- **Gingivectomy***
- **Osseous Graft***
- **Osseous Surgery***
- **Soft Tissue Surgery***
- **Periodontal Maintenance:** Limited to two times during the twelve month period following active and adjunctive periodontal therapy exclusive of gross debridement.
- **Provisional Splinting**
- **Scaling and Root Planing:** Limited to one time per quadrant during a twenty-four month period.

9. Porcelain Onlays

10. Post and Cores: Covered only for teeth that have had root canal therapy.

11. Relining Dentures: Limited to relinings done more than six months after the original insertions. Only one relining per Calendar Year.

12. Re-Cement Bridges, Crowns, and Inlays

13. Repairs to Dentures and Bridges: Limited to repairs or adjustments done within twelve months after the original insertion.

14. Sedative Fillings: Covered as a separate benefit only if no other Dental Services other than examination and radiographs were done during the Visit.

***** Only one of these Dental Services is covered per quadrant during a thirty-six month period.

PART V: EXCLUSIONS

We will not pay any benefits for any of the following:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Service or procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.).
4. Reconstructive surgery regardless of whether or not the surgery is incidental to a Dental Disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Service not directly associated with a Dental Disease or condition.
6. Any Dental Procedure not performed in a dental office, medical facility, or a similar facility whose primary function is to perform Dental Procedures.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on

Dental Therapeutics. This also includes any experimental, investigational or unproven procedure that is the only available treatment for a particular condition if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

8. Dental Services for injuries or conditions covered by Worker's Compensation or employer liability laws, or which are provided without cost to the Insured by any municipality, county, or other political subdivision. This exclusion does not apply to any Dental Services covered by Medicaid or Medicare.
9. Expenses for Dental Services begun prior to the date the Insured's coverage under the Policy starts.
10. Dental Services received after the date an Insured's coverage under the Policy stops, including Dental Services for dental conditions arising prior to the date the insured's coverage stops. This does not apply to any Dental Services that are covered under the Extended Coverage provision.
11. Dental Services provided in a foreign country, unless required as an Emergency.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of natural teeth lost prior to the date the Insured's coverage starts may not occur until twelve months after coverage has been in force for 12 continuous months.
14. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
15. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
16. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
17. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
18. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
19. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
20. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because the Insured did not follow instructions on proper use and care, the Insured is liable for the cost of replacement.
21. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months after the insertion of a prosthesis. After the six month waiting period, relines are covered not more than once every 12 months.
22. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
23. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
24. Procedures related to the reconstruction of an Insured's correct vertical dimension of occlusion (VDO).
25. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
26. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
27. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
28. Treatment of malignant or benign neoplasms, cysts, or other pathology, unless removed through an excision. Treatment of congenital malformations of hard or soft tissue, including excision.

29. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
30. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
31. Acupuncture; acupressure and other forms of alternative treatment.
32. General Anesthesia, except if required for Insureds under 6 years of age or Insureds with behavioral problems or physical disabilities.
33. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
34. Occlusal guards except if prescribed to control habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
35. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

PART VI: HOW TO FILE A CLAIM

A. NOTICE OF CLAIM: The Dentist may submit your claim. If not, you must notify us within 60 days after a covered loss occurs or starts, or as soon as possible. Notice is sent to the plan administrator. You should always include your name, the name of the Insured who received the Dental Services and Procedures, and your Policy Number.

B. CLAIM FORMS: Claim forms are used for filing Proof of Loss. They are sent to the person who is making the claim. If such forms are not furnished before the expiration of fifteen (15) days after the insurer receives notice of any claim under this Policy, the person making such claim shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. The statement should be sent within the time noted for Proof of Loss.

C. PROOF OF LOSS: Written proof of loss must be provided within 90 days after the date of loss. If it is not reasonably possible to furnish the necessary proof within the 90 days, a claim will not be reduced or denied because of failure to do so.

D. GRIEVANCE PROCEDURE: If you would like to file a complaint over a claim or would like information about our grievance procedures, please contact the plan administrator using the phone number on the back of your ID card or by writing to:

[Dental Grievances
P.O. Box 30569
Sandy, UT 84070]

PART VII: HOW WE PAY CLAIMS

A. PAYMENT OF CLAIMS: Payment is made immediately after we receive written Proof of Loss. All benefits are paid to the person making the claim. Any benefits unpaid at your death are paid to your estate.

B. TIME OF PAYMENT OF CLAIM: We will pay benefits as soon as the claimant files written Proof of Loss.

C. EXAMINATION OF DENTAL OR PHYSICIAN RECORDS: We may, at our expense, examine an Insured's Dental and Physician records as often as reasonably necessary while a claim is pending.

PART VIII: OTHER IMPORTANT INFORMATION

A. LEGAL ACTIONS: You may not bring a lawsuit against us (e.g., if we do not pay a claim): (1) during the 60 days after we receive written notice of loss; or (2) after 3 years from the time written proof of loss is required.

B. PRONOUNS: Masculine pronouns also refer to the feminine gender unless stated otherwise.

C. MISSTATEMENT OF AGE: If an Insured's Age is misstated, premiums are changed to what they should be for the Insured's correct age.

D. CANCELLATION: You may cancel this Policy by delivering or mailing written notice to us. You must specify the effective date of your cancellation. We may delay the date you request until your next monthly premium due date. Any unused premium is prorated from the date of cancellation and refunded to you. If you do not specify a date, your cancellation is effective on your next premium due date.

Cancellation is without prejudice to any claim originating prior to the date of cancellation.

E. ENTIRE CONTRACT: This Policy and any endorsements or attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

F. RIGHT TO RECOVERY: Within 12 months of payment, we have the right to recover any benefit payment, in whole or in part, that we paid in error. We will recover the amount we paid in error from the person, Dentist, or Dental Practice that we originally paid the claim

G. REFUND OF UNEARNED PREMIUM: If an Insured dies, any premium that is paid for his coverage beyond the end of the month in which his death occurs is refunded. The refund is paid within 30 days after we receive proof of the Insured's death.

H. INCONTESTABILITY: The validity of a Policy may be contested during the first 24 months of coverage if you fail to give to the best of your knowledge and belief, true and complete answers in your Application. The validity of the Policy may not be contested after it has been in force during the your lifetime for 24 months, except for fraudulent misstatements in his Application, you perform an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage, or non-payment of premiums when due.

I. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the Effective Date. If any do not, they are hereby amended to conform.

J. GRACE PERIOD: You have a grace period of 31 days after the due date to pay each renewal premium. The coverage stays in force if the premium is paid during this grace period. If the premium is not paid within this Grace Period, your Policy will Lapse.

K. RIGHT TO ADJUST PREMIUMS: We may change our Table of Premium Rates. Any change made to your premium will be made on a uniform basis to all insureds in your Class. Class is defined as a group of people with the same rate classification and who resided in the same state when their Policy is issued. We will not increase your rates in the first 12 months of coverage. After that, we will not increase your rates more than once in any 12 month period. We will send to you a notice at least 60 days prior to any rate increase.

L. UNPAID PREMIUM: Any premium due and unpaid may be deducted from a claim payment.

[PART IX: HOW YOU PAY YOUR PREMIUM

A. PREMIUM PAYMENTS: You keep coverage in force by paying the premiums. Your first premium is due as stated in the "When Coverage Starts" provision. After that, premiums are due on the first day of each renewal period. Three payment methods are available: (1) we can bill you directly; (2) you can pay by credit card; or (3) you can pay by automatic deductions from your bank checking or savings account. The Renewal Premium modes are shown on your Policy Schedule. (NOTE: Credit Card Payment is not permitted in some states.)

1. **We Bill You:** Premiums can be paid in advance by using any of the premium modes shown in the Policy Schedule. All premiums are payable to our Administrative Office.

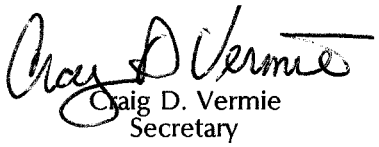
2. **You Pay By Credit Card:** If credit card payment is used, our receiving your credit card billing authorization is treated as payment. The credit card company assumes the duty to pay each premium when due. You are billed by them through the credit card. Premiums are paid for as long as you authorize payment and your credit card remains in effect. This is subject to the option of the credit card company not to make payment if your credit card account is over limit or past due. We will bill you directly if payment is not made by the credit card company.

3. **You Pay By Automatic Bank Account:** If bank account payment is used, our receiving your authorization to deduct premiums from your bank account is treated as payment. The bank pays each premium when due. Premiums are paid for as long as you authorize payment, provided there are enough funds in your bank account to pay the premium. We will bill you directly if payment cannot be automatically deducted from your bank account.

B. PAYMENT CANCELLATION: If you choose to cancel credit card or bank account payments, you must notify us in writing. We will stop your billing. You must pay for any coverage prior to our receiving your notice. If you wish to continue coverage, we will bill you directly.]

IN WITNESS, this Policy is signed by our President and Secretary.

Marilyn Carp
President



Craig D. Vermie
Secretary

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: 2700 W. Plano Pkwy, Plano, TX 75075

1-800-732-1821

REQUIRED OUTLINE OF COVERAGE

SUPPLEMENTAL DENTAL POLICY D493 AR

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Stonebridge Life Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

RENEWABLE AT THE OPTION OF THE COMPANY: We promise to renew this Policy as long as: (1) you pay your premium when due. We will not renew this Policy if: (1) we do not renew it and all other policies that are issued to everyone in your Class or in the state where it was issued; or (2) we do not renew it because you performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

YOUR RIGHT TO EXAMINE THE POLICY FOR 30 DAYS: You may return this Policy and cancel your coverage for any reason within 30 days of the date you receive the Policy. Any premium payment is returned. The Policy is treated as if it never existed. No benefits are paid.

DENTAL COVERAGE. This category of coverage is designed to provide insured persons with dental benefits, subject to any limitations contained in the Policy.

BENEFITS

This Coverage pays benefits for covered Basic and Major Dental Services as detailed in the policy. To be eligible for payment, Dental Services must be received while the Insured's coverage under this Policy is in force. All Dental Services must be Necessary and provided by or under the direction of a Dentist. Dental Services may be provided by a Network Dentist or a non-Network Dentist as defined in the policy.

The benefit amount that we pay for a covered Dental Service is based on the Dental Service's Eligible Expense. Different criteria are used to determine the Eligible Expenses for Dental Services provided by Network Dentists and those provided by non-Network Dentists.

We pay the same percentage of an Eligible Expense when a covered Dental Service is provided by a Network or non-Network Dentist. The percentages that we pay for Preventative, Basic, and Major Dental Services are shown on the Policy Schedule. You are responsible for paying the difference between the benefit amount that we pay and the Eligible Expense. This difference is the Co-Payment. You are also responsible for paying any amounts charged by a non-Network Dentist that exceed an Eligible Expense.

Calendar Year Deductible: No benefits are paid in a Calendar Year for Basic and Major Dental Services until the Insured's Calendar Year Deductible is satisfied. The Calendar Year Deductible is shown on the Policy Schedule. There is no deductible for Preventative Dental Services.
Calendar Year Maximum Benefit: A Calendar Year Maximum Benefit applies to each Insured. It is shown on the Policy Schedule. It is the total amount of benefits that we pay in a Calendar Year for each Insured. You are responsible for any charges for Dental Services that an Insured receives after he has met his Calendar Year Maximum Benefit.

Waiting Period For Major Dental Services: Benefits are not paid for Major Dental Services that are received during a Waiting Period. A Waiting Period begins on an Insured's effective date of coverage. The Waiting Period is shown on the Policy Schedule.

COVERED DENTAL SERVICES

Basic Dental Services

1. Adjunctive Services

Analgesia

Desensitizing Medicament

General Anesthesia: Covered only if required for Insureds who are under the Age of 6 years or Insureds who have behavioral problems or physical disabilities.

Intravenous Sedation and Analgesia

Occlusal Adjustment

Occlusal Guards: Limited to one guard during a five year period

Palliative Treatment: Covered only if no other Dental Service other than examination and radiographs were done during the visit.

2. Minor Restorative Services

Amalgam Restorations: Multiple restorations on one surface will be treated as a single filling.

Composite Resin Restorations

Pin Retention: Limited to two pins per tooth.

Space Maintainers: Limited to Insureds who are under the Age of 16 years and only one time during their lifetime. Benefit includes all adjustments within the six month period after installation.

Provisional Splinting

Major Dental Services

1. Crowns: Limited to one crown per tooth during a 5 year period and only when a filling cannot restore the tooth.

2. Endodontics

Apexification

Apicoectomy and Retrograde Filling

Hemisection

Root Canal Therapy

Root Resection

Therapeutic Pulpotomy

3. Fixed Bridges

4. Full Dentures: No additional allowances for over-dentures or customized dentures.

5. Gold Inlays and Onlays: Limited to one time during a five year period and only where amalgam (silver) fillings cannot restore the tooth.

6. Oral Surgery

Alveoloplasty

Biopsy

Frenectomy

Incision and Drainage

Removal of a Benign Cyst

Removal of Exostosis

Root Recovery

Root Removal

Simple Extraction

Surgical Extraction of Erupted Teeth and Roots

Surgical Extraction of Impacted Teeth

7. Partial Dentures: No additional allowances for precision or semi-precision attachments.

8. Periodontics

Crown Lengthening*

Gingivectomy*

Osseous Graft*

Osseous Surgery*

Soft Tissue Surgery*

Periodontal Maintenance: Limited to two times during the twelve month period following active and adjunctive periodontal therapy exclusive of gross debridement.

Provisional Splinting

Scaling and Root Planing: Limited to one time per quadrant during a twenty-four month period.

9. Porcelain Onlays

10. Post and Cores: Covered only for teeth that have had root canal therapy.

11. Relining Dentures: Limited to relinings done more than six months after the original insertions. Only one relining per Calendar Year.

12. Re-Cement Bridges, Crowns, and Inlays

13. Repairs to Dentures and Bridges: Limited to repairs or adjustments done within twelve months after the original insertion.

14. Sedative Fillings: Covered as a separate benefit only if no other Dental Services other than examination and radiographs were done during the Visit.

***** Only one of these Dental Services is covered per quadrant during a thirty-six month period.

EXCLUSIONS

We will not pay any benefits for any of the following:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Service or procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.).
4. Reconstructive surgery regardless of whether or not the surgery is incidental to a Dental Disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Service not directly associated with a Dental Disease or condition.
6. Any Dental Procedure not performed in a dental office, medical facility, or a similar facility whose primary function is to perform Dental Procedures.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. This also includes any experimental, investigational or unproven procedure that is the only available treatment for a particular condition if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Dental Services for injuries or conditions covered by Worker's Compensation or employer liability laws, or which are provided without cost to the Insured by any municipality, county, or other political subdivision. This exclusion does not apply to any Dental Services covered by Medicaid or Medicare.
9. Expenses for Dental Services begun prior to the date the Insured's coverage under the Policy starts.
10. Dental Services received after the date an Insured's coverage under the Policy stops, including Dental Services for dental conditions arising prior to the date the insured's coverage stops. This does not apply to any Dental Services that are covered under the Extended Coverage provision.
11. Dental Services provided in a foreign country, unless required as an Emergency.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of natural teeth lost prior to the date the Insured's coverage starts may not occur until twelve months after coverage has been in force for 12 continuous months.
14. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
15. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
16. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
17. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
18. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.

19. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
20. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because the Insured did not follow instructions on proper use and care, the Insured is liable for the cost of replacement.
21. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months after the insertion of a prosthesis. After the six month waiting period, relines are covered not more than once every 12 months.
22. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
23. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
24. Procedures related to the reconstruction of an Insured's correct vertical dimension of occlusion (VDO).
25. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
26. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
27. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
28. Treatment of malignant or benign neoplasms, cysts, or other pathology, unless removed through an excision. Treatment of congenital malformations of hard or soft tissue, including excision.
29. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
30. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
31. Acupuncture; acupressure and other forms of alternative treatment.
32. General Anesthesia, except if required for Insureds under 6 years of age or Insureds with behavioral problems or physical disabilities.
33. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
34. Occlusal guards except if prescribed to control habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
35. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

SUPPLEMENTAL DENTAL APPLICATION

[I want coverage for o Me only o Me and Spouse o Me and Children o Me and Family]
[o Yes, I would like to add orthodontic coverage for my child(ren)]

[(Please Print)
Your Name o Mr. o Mrs. o Miss _____
First Middle Initial Last
Address _____
Street or RD #
City _____ **State** _____ **Zip** _____

Your Date of Birth _____ **Age** _____ **Male o Female o Phone #** (_____)_____
Month Day Year Area Code

Spouse's Name (if to be insured) _____
First Middle Initial Last

Spouse's Date of Birth _____ **Age** _____ **Male o Female o Phone #** (_____)_____
Month Day Year Area Code

Child's Name (if to be insured) _____
First Middle Initial Last

Child's Date of Birth _____ **Age** _____ **Male o Female o Phone #** (_____)_____**]**
Month Day Year Area Code

[(To cover additional children, please include their information on a separate sheet of paper.)]

[PAYMENT INFORMATION [(Select how you want to pay, from a, b, or c)

(a) o Bill me directly. I have enclosed my first month's premium.

(b) o Deduct from my Bank/Credit Union checking Account (Your payment is made directly through your bank or credit union share draft account.) IMPORTANT: Write "VOID" on a blank check from this account and send it with this application.

(c) o Charge my Credit Card (check one): o Visa o Master Card o Discover (Your payments are automatically billed to your credit card account and shown as part of your statement.)

Account # _____Expiration Date _____

Subject to my accounts' rules, charge or deduct my premiums (including future changes to my insurance) by electronic or other method from the credit card or checking account I have selected above. I can cancel this payment method at any time by writing to you.]

I would like to apply for the [Stonebridge Life Insurance Company's Supplemental Dental Insurance Plan]. I understand that coverage begins on the policy effective date as shown on my Policy Schedule and Stonebridge Life receives my first premium payment **[**prior to/within 21 days after the effective date**]**. I understand that only Basic Dental Services received after the effective date and Major Dental Services received [180] days after the effective date will be covered. I understand that I can have only one supplemental dental insurance policy/certificate with the company. **[**I have read my state's fraud statement on the back of this application**]**.

[Your] Signature (required) X_____ **Date** _____

[Spouse Signature (if to be insured) X _____ **Date** _____**]**

[Stonebridge Life Insurance Company
Administrative Offices: 2700 W. Plano Parkway, Plano TX 75075]
[Home Office: Rutland, VT]

[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Residents of DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Residents of LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Residents of MAINE, TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Residents of PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**]**

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval

Rate Change Type:

Overall Percentage of Last Rate Revision:

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Stonebridge Life Insurance Company	%	%				%	%

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:		Attachments
Approved-Closed	Rates - D493 AR	D493 AR	Other	Previous State Filing Number: Rate Action Other Explanation:	38713	DN AR0041315R02.PDF

Type: **Dental Insurance**

Company: **Stonebridge Life Insurance Company**

Form: **D493 AR**

Rates are effective March 1, 2008

Rate Table: **A**

	Region			
	1	**2**	**3**	**4**
Principal Insured	177.97	197.08	249.57	327.21
Prinicipal Insured + Spouse	355.94	394.16	499.14	654.42
Prinicipal Insured + Children	313.93	347.73	440.28	577.21
Prinicipal Insured + Family	504.86	559.06	708.00	928.18

Modal Factor	Direct Bill	Automated Payment
Monthly	0.092600	0.083333
Quarterly	0.262500	0.236250
Semi-Annual	0.510000	0.459000
Annual	1.000000	0.900000

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/24/2009
Comments:
Attachment:
AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Application **Review Status:** Approved-Closed 06/24/2009
Comments:
See Form Schedule

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 06/24/2009
Comments:
See Form Schedule

Satisfied -Name: Explanation of Variables - D493 AR **Review Status:** Approved-Closed 06/24/2009
Comments:
Attachment:
Explanation of Variables - D493 AR.PDF

Satisfied -Name: AR Actuarial Exhibit C **Review Status:** Approved-Closed 06/24/2009
Comments:
Attachment:
AR Actuarial Exhibit C .PDF

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 06/24/2009
Comments:
Attachment:

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Cover Letter.PDF

SERFF Tracking Number:	*AEGX-126202433*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42748*
Company Tracking Number:	*DN AR0041315C02*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041315C02*		

Satisfied -Name: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT

Review Status:
Approved-Closed 06/24/2009

Comments:

Attachments:
AR - NAIC TRANSMITTAL DOCUMENT.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF
AR - NAIC RATE FILING ATTACHMENT.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
D493 AR	42.2

Signed: _____

Name: Edward G. Weigand

Title: Assistant Secretary

Date: 06-23-09

Explanation of Variables

D493 AR – Individual Supplemental Dental Policy

Page 1

1. Administrative address/phone number is made variable to allow us to administer the product from other locations or to accommodate any changes in phone numbers or addresses related to moves.

Page 2

1. This page has mostly self-explanatory variables (name, address, premiums, etc.)

Page 4

1. "before/within 21 days" is used to accommodate our different administrative sites as we have different billing systems.

Page 11

1. As we use a TPA to administer claims, we keep information about the TPA, Dental Benefit Providers (DBP), variable to accommodate them. The customer will have access to up-to date claims contact information via their membership card.

Page 13

1. "Part VIII – How to Pay Your Premium" language will vary according to available payment options.

IGH003 – Individual Supplemental Dental Application

1. The variability of coverage level and dependent coverage allows us to auto populate fields and tailor applications specifically for the customer (or to allow data to be input from another source such as telemarketing)
2. Much of the rest of the application is variable to accommodate the "John Doe" nature of the applications.
3. Payment information is variable to accommodate the billing options that are available with the marketing campaign.
4. Fraud language is included so that we can use a standard application in multiple states.
5. [Your] in the signature line, can be replaced with "insured" or some other appropriate noun.
6. Administrative address/phone number is made variable to allow us to administer the product from other locations or to accommodate any changes in phone numbers or addresses related to moves.

Actuarial Exhibit C

Arkansas – ZIP Codes

REGION 1 – ZIP Codes Beginning With: 716, 717, 718, 719, 722, 723, 724, 726, 727, 728

REGION 2 – ZIP Codes Beginning With: 720, 721, 725, 729

STONEBRIDGE LIFE
Insurance Company

Administrative Office | 2700 W. Plano Parkway | Plano | Texas 75075

June 23, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: ***RESUBMISSION***
Form and Rate Filing - D493 AR, et al. - Individual Supplemental Dental Insurance Policy
Health Dental
Company Filing#: DN AR0041315C02
Stonebridge Life Insurance Company NAIC#: 468-65021 FEIN#: 03-0164230
Previously submitted under Insurance Dept. File #: 38713

Dear Commissioner Bradford:

The above captioned Individual Supplemental Dental Insurance Policy and related materials are being resubmitted for your department review and approval. The following is in response to your objection letter dated April 23, 2008.

Objection 1

Pursuant to ACA 23-79-129, we have revised the Newborn and Adopted Children provision to reflect coverage for newborn infants to be 90 days.

Moreover, pursuant to ACA 23-79-137, we have revised the Newborn and Adopted Children provision to reflect coverage for adopted children to begin on the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. The coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the adopted child.

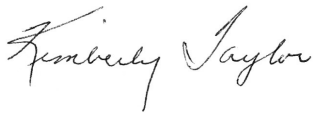
Objection 2

Pursuant to ACA 23-85-131(b) and Bulletin 14-81 with respect to handicapped dependents, we have revised the EXCEPTION under Item #2 on page 5 to state: ***EXCEPTION:*** *At age 26, a Covered Dependent child's coverage may continue under this Policy as long as it remains in force if the child is incapable of self support due to a mental or physical handicap and remains in such condition. We must receive your written request prior to the child attaining age 26. The premium charged is that of a Covered Dependent child.*

Please note form D493 AR is ***replacing*** form D493.

We believe these revisions will assist in your further review and with optimism, subsequent approval. Your time and consideration regarding this filing is greatly appreciated.

Sincerely,



Kimberly Taylor, AIRC, ACS
Filing Specialist
(800) 233-4624, ext. 5261
(410) 209-5910 (Fax)
Kimtaylor@aegonusa.com (E-mail)

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014		VT	A&H	468	65021	03-0164230	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Kimberly Taylor, AIRC, ACS 520 Park Avenue, MS #A507 Baltimore MD 21201		800-233-4624, ext. 5261	410-209-5910	kimtaylor@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	DN AR0041315C02
7.	☐ **New Submission** ☒ **Resubmission**	Previous file # 38713
8.	**Market**	☒ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H10I Individual Health - Dental
10.	**Product Coding Matrix Filing Code**	H10I.000 Health - Dental
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☒ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☒ **RATES** ☒ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☒ Statement of Variability ☒ Certifications ☒ Actuarial Memorandum ☒ Other: Actuarial Exhibit

12.	**Filing Submission Date**	June 23, 2009
13.	**Filing Fee (If required)**	Amount $100.00 Check Date N/A Retaliatory ☐ Yes ☒ No Check Number N/A
14.	**Date of Domiciliary Approval**	Not filed in domicile state.
15.	**Filing Description:**	

An Individual Supplemental Dental Insurance Policy and related materials are being resubmitted for your department review and approval. The following is in response to your objection letter dated April 23, 2008.

Objection 1

Pursuant to ACA 23-79-129, we have revised the Newborn and Adopted Children provision to reflect coverage for newborn infants to be 90 days.

Moreover, pursuant to ACA 23-79-137, we have revised the Newborn and Adopted Children provision to reflect coverage for adopted children to begin on the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. The coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the adopted child.

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Please note form D493 AR is replacing form D493.

We believe these revisions will assist in your further review and with optimism, subsequent approval. Your time and consideration regarding this filing is greatly appreciated.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Kimberly Taylor, AIRC, ACS Title Filing Specialist

Signature Kimberly Taylor Date 06-23-09

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	DN AR0041315C02
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Individual Supplemental Dental Insurance Policy	D493 AR	☐ Initial ☒ Revised ☐ Other	
02	Outline of Coverage	D493 O.C.	☐ Initial ☐ Revised ☒ Other resubmission	38713
03	IGH003 - Application	IGH003	☐ Initial ☐ Revised ☒ Other resubmission	38713
04			☐ Initial ☐ Revised ☐ Other	
05			☐ Initial ☐ Revised ☐ Other	
06			☐ Initial ☐ Revised ☐ Other	
07			☐ Initial ☐ Revised ☐ Other	
08			☐ Initial ☐ Revised ☐ Other	
09			☐ Initial ☐ Revised ☐ Other	
10			☐ Initial ☐ Revised ☐ Other	
11			☐ Initial ☐ Revised ☐ Other	

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number			DN AR0041315C02	
This filing corresponds to form filing company tracking number			N/A	
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing				**%**
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01	Rates - D493 AR	D493 AR	☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☒ **Other** resubmission	38713
02	Actuarial Memo - D493 AR	D493 AR	☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☒ **Other** resubmission	38713
03	Actuarial Exhibit C	D493 AR	☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☒ **Other** resubmission	38713
04			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
05			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
06			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
07			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
08			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
09			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
10			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
11			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
12			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	